IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 25/1 et.seq. of (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

TEMPORARY DENTAL / DENTAL HYGIENIST PERMIT

SUPPORTING DOCUMENT

TP-DEN

NOTE: A Dental Permit issued pursuant to section 19.2 of the Illinois Dental Practice Act, shall authorize the practice of dentistry or dental hygiene in a specified area of the state for a period of time not to exceed 10 consecutive days in a year. The applicant may be required to appear before the Board for an interview prior to, and as a requirement for, the issuance of such temporary permit.

APPLICANT: Complete the applicant section of this form. Forward the form to the Responsible person/parties where the invitation/appointment and treatment is to be performed.

1. NAME LAST FIRST MIDDLE

2. DATE OF BIRTH __ __ / __ __ / __ __ __ __ (Month / Day / Year)

3. SOCIAL SECURITY NUMBER _ _ _ - _ _ - _ _ _ _

4. ADDRESS STREET, CITY, STATE, ZIP CODE

5. MAIDEN OR GIVEN SURNAME

6. Dental Education Program Completed.

Name of Program	Location of Program	Year of Graduation

7. List all states where you hold active license as a dentist or hygienist:

8. Have you been convicted of any crime under the laws of any jurisdiction of the United States: (a) which is a felony; or (b) which is a misdemeanor directly related to the practice of the profession within the last five (5) years?

☐ Yes ☐ No

9. Have you had a license related to the practice of dentistry revoked, suspended, or placed on probation by another jurisdiction within the last five (5) years? ☐ Yes ☐ No

If so, have appropriate board of dentistry complete CT-DEN form and attach copies of disciplinary action.

RESPONSIBLE PERSON/ADMINISTRATOR: Complete this portion of this form, then return the form to the applicant.

A. NAME OF SPONSORING ORGANIZATION

B. LOCATION OF EVENT (Street, City, State, Zip Code)

C. THE TERM OF PRACTICE NOT TO EXCEED 10 DAYS

From __ __ /__ __ /__ __ __ __ To __ __ /__ __ /__ __ __ __

D. BRIEF DESCRIPTION ON HOW THE SERVICES OF THE APPLICANT WILL IMPROVE THE WELFARE OF THE RESIDENTS AND TREATMENT PROCEDURES TO BE PERFORMED.

I do hereby declare that the above-named applicant has been invited/appointed to study, demonstrate or perform a specific clinical subject or technique as a visiting dentist or dental hygienist for 10 consecutive days or less.

Signature of Responsible Person

Print or Typed Name of Responsible Person

Date

I certify the information and documents contained in this application are true and correct to the best of my knowledge. I understand should any of the information or documents contained herein be proven false, it may result in the denial of my Temporary Permit or other appropriate disciplinary action.

Signature

Date